STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155704	A. BUILDING 01 B. WING	02/29/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WALDRON HEALTH AND REHAB CENTER	505 N MAIN ST WALDRON, IN 46182

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0000	A Life Safety Code Recertification survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 02/29/12 Facility Number: 000423 Provider Number: 155704 AIM Number: 100290450 Surveyor: Phillip Komsiski, Life Safety Code Specialist At this Life Safety Code survey, Waldron Health and Rehab Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors and none in the resident rooms. The facility has a capacity of 79 and had a census of	K0000	This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	55 at the time of this survey. Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 03/06/12 The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			

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K0029 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 Based on observation and interview, the facility failed to ensure 1 of 1 glass sliding windows separating the kitchen, a hazardous area, from the corridor would close automatically with the fire alarm system to maintain a smoke resistant barrier. This deficient practice could affect 12 residents observed in the dining room as well as visitors and staff. Findings include: Based on observation on 02/29/12 at 3:35 p.m. with the Maintenance Supervisor, one set of glass sliding windows protected the opening from the kitchen to the main dining room which did not close automatically upon activation of the fire alarm system. The main dining room was open to the corridor. Based on interview on 02/29/12 at 3:37 p.m. with the Maintenance Supervisor, it was	K0029	K 029 1.) How corrective action will be accomplished for those affected. No residents were affected by this alleged deficient practice 2.) How corrective action will be accomplished for those residents having potential to be affected. No residents were affected by this alleged deficient practice. 3.) What measures will be put in place/systematic changes made to insure corrections. Stainless steel self-closing door to be installed at opening between kitchen and dining room. Requisition is in process thru vendor. 4.) How the facility plans to monitor performance to ensure deficient practices do not reoccur. Maintenance director/Executive Director to ensure safe and accurate installation of required equipment. 5.) Date of completion 03/30/2012	03/30/2012

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	acknowledged the sliding glass windows had to be manually shut and would not close automatically with activation of the fire alarm. 3.1-19(b)			

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K0056 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 Based on observation and interview, the facility failed to ensure 2 of 3 sprinkler heads in the maintenance room on south hall were installed a minimum of 6 feet apart. NFPA 13, Section 5-6.3.4, "Minimum Distance Between Sprinklers" states sprinklers shall be spaced not less than 6 feet on center. This deficient practice could affect 8 residents on south hall as well as visitors and staff Findings include: Based on observation on 02/29/12 at 3:40 p.m. with the Maintenance Supervisor, the maintenance room on south hall had two sprinkler heads on the west part of the ceiling which were five feet apart. Based on interview on 02/29/12 at 3:42 p.m. with the Maintenance Supervisor, it was acknowledged the two sprinkler	K0056	K 056 1.) How corrective action will be accomplished for those affected. No residents were affected by this alleged deficient practice 2.) How corrective action will be accomplished for those residents having potential to be affected. No residents were affected by this alleged deficient practice. 3.) What measures will be put in place/systematic changes made to insure corrections. Safe-Care to remove extra sprinkler head from sited location. **(Completed 03/15/2012)** 4.) How the facility plans to monitor performance to ensure deficient practices do not reoccur. Maintenance director/Executive Director to ensure removal of duplicate equipment. Maintenance to ensure that any new sprinkler head installation is within this regulation 5.) Date of completion 03/30/2012	03/30/2012

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	heads in the maintenance room on south hall were less than six feet apart. 3.1-19(b)			